

Lawrence County Government

Extended Illness Leave Bank Request Form

LB ID Number	Employee Information					
Full Name:						
Address:	Last First	М.І.				
710010001	Street Address	Apartment/Unit #				
Home Phor	City State ne:(ZIP Code				
E-mail Add	ress:					
Social Sec.	#:					
Birth Date:	Marital Status:					
Spouse's N	lame:					
Spouse's E	Employer: Spouse's Work Phone:					
	Job Information					
Title:	Work Hours:					
Supervisor:	Department:					
I Understa	and that:					
I must be an employee who is eligible to accrue and use sick leave.						
	I must be on approval leave of absence.					
	I am suffering a serious injury or illness causing me to be incapacitated.					
	I must provide a physician's certification of illness or injury, which includes an estimated return to work date, to the Office of Accounts & Budgets.					
	I must exhaust all paid leave (sick, vacation, & comp time off) before I am eligible to receive the hours from the leave bank.					
	I may not be on any other pay status, receiving State disability benefits, or receiving Worker's Compensation benefits and will notify the Office of Accounts & Budgets of any changes to my pay status.					
	The identity of donors to the leave bank shall not be made known to me.					
	My Leave Bank time will stop in accordance with the Leave Bank Policy.					

My participation is subject to the provisions as outlined in the Leave Bank Policy. I have donated a minimum of one day this year as well as my original membership donation of two days.								
-COMPLETED BY Office of Accounts & Budgets & Leave Bank Committee-								
Part time PMLA Part time PMLA Part time PMLA	Total Leave Hours Requested	Requestor's Rate of Pay	Red	questor's Leave Bank ID				
Signature of LB Representative/Designee Funding O GF O SW O HWY O LIBRARY								
Request Received on:	Credit Date of	Requested Leave	Signati	ure of LB Record Keeper				

l,	, hereby requ	uest the use of	_ days* of leave from the				
Leave Bank, for my serious illness or injury. I have attached form LB-1002 Certification of							
Physician and have notified my immediate supervisor. The purpose of my leave meets the							
conditions of the Leave Bank Policy and as described below.							
*Shou	*Should not exceed 30 consecutive days (240 hours)						
!	A. Catastrophic injury or illness is defined as a life threatening condition or combination of conditions affecting the mental or physical health of the employee or immediate family member or household. The catastrophic illness or injury must require the services of a physician.						
Catastrophic injury or illness involves:							
 A period of incapacity or treatment connected with inpatient care (e.g., an overnight stay) in a hospital, hospice, or residential medical care facility; or A period of incapacity requiring absence of more than ten consecutive working days, and that also involves continuing treatment by (or under the supervision of) a licensed health care provider; or A period of incapacity due to a chronic serious health condition (e.g., asthma, diabetes, epilepsy, etc.); or A period of incapacity that is long-term due to a condition for which treatment may be ineffective (e.g., stroke, terminal disease, etc.); or An absence to receive multiple treatments (including any period of recovery there from) either for restorative surgery after an accident or other injury, or for a chronic condition such as cancer or kidney disease. A period of incapacity means that the employee cannot do her/his job and does not have the ability to perform normal activities in her/his daily life or engage in normal recreational activities. Convalescence means returning to health after illness or incapacity, or gradual healing (through rest) after sickness or injury. Convalescence is a synonym for recovery and recuperation. 							
Sigr	ned By Date	9					
-CHECKLIST COMPLETED BY Office of Accounts & Budgets -							
□ Leave	Request Form Signed & Completed	☐ Certification of Physicians For	rm LB-1003 Attached				
☐ Leave Bank Membership Verified		□Requestor Has or is About to	Exhaust all Paid Time Off				
□ A Worl	☐ A Worker's Comp Claim Has Not Been Filed Date Time was exhausted or predicted date						